		AND HUMAN SERVICES ,		,	. 1	un.		۲		TO/08/2015 APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES L	127		_ [[//4/	15	C		0938-0391
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			BUILDIN	NG 01		(X3) DAT	E SURVEY IPLETED
		. 445239	8. WING	·	···				09/	28/2015
NAME OF F	ROVIDER OR SUPPLIER			STR	REET ADI	DRESS, C	ITY, STATE,	ZIP CODE	<u> </u>	-
LIFE CAF	RE CENTER OF MOR	GAN COUNTY		419	SOUTH	KINGS1	TON STREE	Τ		
_				WA	RTBU	RG, TN	37887			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(E	ACH COR	ER'S PLAN OF RECTIVE AC RENCED TO DEFICIEN	TION SHOUL THE APPROF	D BE	(X5) COMPLETION DATE
SS=E	Any door in an exit enclosure, horizonta hazardous area end devices arranged to doors by zone or the activation of: a) the required many b) local smoke detection synoke detection synoke detection synohe is the automatic spring. 2.2.2.6, 7.2.1.8.2	inkler system, if installed. In a system in installed in the system in	K	up re al re the the we are in control are	pholding esidents Il applica equirem ne State ne best i ve provid vhile this dmission a good fa onducte his Plan nd State 021	g the high able stan ents. The of Tenne interest of de. s plan in n of valid aith as a in of Correct requirer What co accompl have been practice The Mai the fire of	errective acti lished for the en effected l ? ntenance Di doors locate	of of care for antial complegulatory rks in cooper the considered and in the corrector has an in the corre	rits liance with ration with alth toward services d ubmitted e survey 30, 2015. a Federal c s found to ent djusted ridor by	n d oct. 26, 2015
	failed to ensure corropen by approved do The findings include 1. Observation and Maintenance Director confirmed the corrichad one side that we latch. 2. Observation and Maintenance Director confirmed the corrich department had one a positive latch. These findings were	idor fire doors were only held evices. : interview with the or, on 9/29/2015 at 11:17 AM dor fire doors by room 201 ould not close to a positive interview with the or, on 9/29/2015 at 11:35 AM dor fire doors by the rehab side that would not close to verified by the Maintenance	·		2.	automat was com How will having the same de The Mai- construct all fire de fire alare	01 and the ritically close in pleted on 9, I you identifie the potential ficient praction of the I oors are posmithly bases.	to a positive /30/2015. y other resid to be affect ice? rector will expuilding to e sitively latchisounded. The	latch. This lents ed by the xamine nsure that ng when	
i	Supervisor and ackr			İ						
BORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		f*.	TIT	LE		···· !	(X6) DATE
5 La	41	Ex	within	1	THECH	lot			10/15	115

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 01 445239 B. WING 09/28/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 419 SOUTH KINGSTON STREET LIFE CARE CENTER OF MORGAN COUNTY WARTBURG, TN 37887 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) What measures will be put into place or 3. K 021 Continued From page 1 K 021 what systemic changes will be made to Administrator during the exit conference on ensure that the deficient practice does not 9/29/2015. recur? K 029 NFPA 101 LIFE SAFETY CODE STANDARD K 029 The Maintenance Director or maintenance SS=D One hour fire rated construction (with ¼ hour assistant will conduct a monthly fire drill to fire-rated doors) or an approved automatic fire ensure our facility maintains the fire doors extinguishing system in accordance with 8.4.1 are positively latching. and/or 19.3.5.4 protects hazardous areas. When How will the corrective action be the approved automatic fire extinguishing system monitored to ensure the deficient practice option is used, the areas are separated from other spaces by smoke resisting partitions and will not reoccur, i.e., what quality doors. Doors are self-closing and non-rated or assurance program will be put into place? field-applied protective plates that do not exceed The Maintenance Director or maintenance 48 inches from the bottom of the door are assistant will report findings of the audit to permitted. 19.3.2.1 the interdisciplinary PI committee for 3 months or until 100% compliance is achieved. The Performance improvement committee This STANDARD is not met as evidenced by: Based on observation and interview, the facility includes the Executive Director, Director of Nursing, Medical Director, Consultant failed to ensure hazardous area doors closed to Pharmacist, Director of Rehabilitation a positive latch. (NFPA 101, 19-3.6.3.) Services, director of Health Information, 33.3.3.6.4.4 (3) Director of Social Services, Director of The findings include: Food Services, Director of Maintenance, Staff Development Coordinator, Director Observation and interview with the Maintenance of Environmental Services, and other Director, on 9/29/2015 at 11:35 AM confirmed Interdisciplinary team members. The PI corridor doors to central supply room failed to committee will review the results of the close to a positive latch. audit. If deemed necessary by the This finding was verified by the Maintenance committee, the process will be Supervisor and acknowledged by the evaluated/revised and /or the audits Administrator during the exit conference on reviewed for 3 months or until 100% 9/29/2015. compliance is achieved. K 052 NFPA 101 LIFE SAFETY CODE STANDARD K 052 SS=F A fire alarm system required for life safety is

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES				FORM APPROVED <u>B NO. 0938-0391</u>				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ORDER/SUPPLIER/ORDER/SUPPLIER/ORDER/SUPPLIER/ORDER/SUPPLIER/ORDER/SUPPLIER/ORDER/SUPPLIER/ORDER/SUPPLIER/ORDER/SUPPLIER/ORDER/SUPPLIER/ORDER/SUPPLIER/ORDER/SUPPLIER/ORDER/S		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	l.	(3) DATE SURVEY COMPLETED				
		445239	B. WING			09/28/2015				
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE						
LIFE CARE CENTER OF MORGAN COUNTY				419 SOUTH KINGSTON STRI WARTBURG, TN 37887	EET					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BI TO THE APPROPRIA	E COMPLETION DATE				
	9/29/2015. NFPA 101 LIFE SA One hour fire rated fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro the approved autoroption is used, the other spaces by sn doors. Doors are sfield-applied proted	AFETY CODE STANDARD I construction (with ¾ hour an approved automatic fire em in accordance with 8.4.1 atects hazardous areas. When matic fire extinguishing system areas are separated from noke resisting partitions and self-closing and non-rated or tive plates that do not exceed bottom of the door are	K 02	-	se residents ffected by the ector has central supply to ditive latch. This 30/2015. other residents o be affected by	Nov. 2, 2015				
K 052 SS=F	Based on observational failed to ensure had a positive latch. (Ni 33.3.3.6.4.4 (3) The findings include Observation and interestor, on 9/29/20 corridor doors to declose to a positive I. This finding was ve Supervisor and ack Administrator during 9/29/2015. NFPA 101 LIFE SA	terview with the Maintenance 015 at 11:35 AM confirmed intral supply room failed to atch. rified by the Maintenance nowledged by the g the exit conference on	K 05	The Maintenance Bire examine construction to ensure that all fire positively latching who been sounded. This is monthly bases. 3. What measures will be or what systemic charmade to ensure that the practice does not recult the Maintenance Direct maintenance assistant monthly fire drill to enthal maintenance that the fire door latching.	of the building doors are en fire alarm has done on a e put into place nges will be the deficient ur?					
	·	required for life safety is								
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: FGGM2	f F	Facility ID: TN6501	If continuation	on sheet Page 2 of 6				

FORM APPROVED

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 (X3) DATE SUMPLEMENT OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 419 SOUTH KINGSTON STREET WARTBURG, TN 37887 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	PPROVEĎ 1938-0391
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MORGAN COUNTY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 419 SOUTH KINGSTON STREET WARTBURG, TN 37887 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CONSTRUCTIVE ACTION SHOULD BE CONSTRUCT	SURVEY .
LIFE CARE CENTER OF MORGAN COUNTY 419 SOUTH KINGSTON STREET WARTBURG, TN 37887 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	8/2015
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CONTROL TAG CROSS-REFERENCED TO THE APPROPRIATE	
	(X5) COMPLETION DATE
K 021 Administrator during the exit conference on 9/29/2015. K 029 SS=0 NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-appited protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure hazardous area doors closed to a positive latch. (NFPA 101, 19-3.6.3.) 33.3.3.6.4.4 (3) The findings include: Observation and interview with the Maintenance Director, on 9/29/2015 at 11:35 AM confirmed corridor doors to central supply room failed to close to a positive latch. This finding was verified by the Administrator during the exit conference on	
9/29/2015. K 052 NFPA 101 LIFE SAFETY CODE STANDARD K 052 SS=F A fire alarm system required for life safety is	

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 445239 B. WING 09/28/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 419 SOUTH KINGSTON STREET LIFE CARE CENTER OF MORGAN COUNTY WARTBURG, TN 37887 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) K 052: Continued From page 2 K 052 installed, tested, and maintained in accordance Oct 26, 2015 K 052 with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance What corrective action(s) will be and testing program complying with applicable accomplished for those residents requirements of NFPA 70 and 72. found to have been effected by the deficient practice? The Maintenance Director along with the contracted Sprinkler Company (CBS) will replace the part of the fire system that controls the strobes. This work is scheduled for 10/21/2015. How will you identify other residents This STANDARD is not met as evidenced by: having the potential to be affected by Based on observation and interview, the facility the same deficient practice? failed to maintain the fire alarm system.(NFPA 72) The Maintenance Department will The findings include: continue to examine the system to Observation during a fire drill with the maintenance director on 9/29/15 at 11:18 AM assure all working properly at all confirmed a trouble light on the fire alarm panel times. CBS will do their routine and the strobes failed to flash upon fire alarm checks to assure all is working activation. properly also. The maintenance department will do monthly and as Interview with the maintenance director on needed. 9/29/15 at 11:18 AM confirmed he was aware of the strobes not working. What measures will be put into place to maintain the fire alarm system. or what systemic changes will be These findings were verified by the Maintenance made to ensure that the deficient Supervisor and acknowledged by the practice does not recur? Administrator during the exit conference on 9/29/2015. The Maintenance Director or NFPA 101 LIFE SAFETY CODE STANDARD K 062 i K 062 maintenance assistant will conduct a SS=E monthly audit-for 3 months to ensure Required automatic sprinkler systems are our facility system is functioning continuously maintained in reliable operating properly. condition and are inspected and tested 19.7.6, 4.6.12, NFPA 13, NFPA 25, periodically.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	KS FUR MEDICARE	E & MEDICAID SERVICES				OWR NO	<u>. 0938-0391</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		445239	B. WING			09	/28/2015
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP COD		
LIFE CA	RE CENTER OF MOR	GAN COUNTY		!	19 SOUTH KINGSTON STREET VARTBURG, TN 37887		
(X4) ID PREFIX TAG	! (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
K 052	with NFPA 70 Natio 72. The system has and testing program	age 2 nd maintained in accordance onal Electrical Code and NFPA s an approved maintenance n complying with applicable FPA 70 and 72. 9.6.1.4	K	052	4. How will the corrective action be monitored to ensure the deficie practice will not reoccur, i.e., where quality assurance program will be into place? The Maintenance Director or maintenance assistant will report findings of the audit to the interdisciplinary PI committee for months or until 100% compliance achieved.	nt nat oe put rt or 3	
	Based on observat failed to maintain the The findings include Observation during maintenance direct confirmed a trouble and the strobes faile activation.				The Performance improvement committee includes the Executive Director, Director of Nursing, Med Director, Consultant Pharmacist, Director of Rehabilitation Services director of Health Information, Director of Social Services, Director of Maintenance, Staff Development Coordinator, Director of Finite Interdisciplinary team members. PI committee will review the rest of the audit. If deemed necessar	edical ess, tor of t er The ults y by	
	the strobes not work to maintain the fire a These findings were Supervisor and ack	king. alarm system. e verified by the Maintenance			the committee, the process will be evaluated/revised and /or the aureviewed for 3 months or until 10 compliance is achieved. K 062	be Idits	
K 062 SS=E	NFPA 101 LIFE SAI Required automatic continuously mainta condition and are in	FETY CODE STANDARD sprinkler systems are ained in reliable operating aspected and tested 6, 4.6.12, NFPA 13, NFPA 25,	ΚO)62 1	What corrective action(s) will be accomplished for those residents found to have been effected by t deficient practice? The Maintenance Director along the sprinkler company has audite.	; he with	Nov. 2, 2015

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 445239 B. WING 09/28/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 419 SOUTH KINGSTON STREET LIFE CARE CENTER OF MORGAN COUNTY WARTBURG, TN 37887 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION 1D (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) sprinkler heads throughout the K 062 | Continued From page 3 K 062 building. Planes to replace head in dishwasher room will be accomplished on October 27th, 2015. All lint and foreign material has been removed with all sprinkler heads. All This STANDARD is not met as evidenced by: escutcheons have been checked and Based on observation, the facility failed to replaced if needed. All has been maintain the sprinkler system. completed by October 27, 2015. The findings include: Observation with the maintenance director on 2. How will you identify other residents 9/29/15 between 9:00 AM and 3:00 PM, revealed having the potential to be affected by the following: the same deficient practice? 1. One tarnished sprinkler head in the Maintenance Department will dishwasher room. (NFPA 25, 5.2.1.1.1) 2. One of one sprinkler head in the cooler was examine all sprinkler heads to ensure covered with lint and foreign material. (NFPA 25, that all are clean from any paint, lint, 5.2.1.1.1) dust or debris to assure proper 3. One sprinkler head in the shower room working order is obtained. across from 208 was covered with foreign What measures will be put into place material. (NFPA 25, 5.2.1.1.1) 4. One sprinkler head in the laundry was or what systemic changes will be covered with foreign material. (NFPA 25. made to ensure that the deficient practice does not recur? 5.2.1,1.1) 5. In the secure unit storage room, a sprinkler The Maintenance Director or escutcheon has moved and is now obstructing maintenance assistant are conducting the deflector. a bi monthly audit and cleaning all routinely to assure compliance and all 6. An escutcheon is missing in the freezer. are in proper working order. These findings were verified by the Maintenance Supervisor and acknowledged by the 4. How will the corrective action be Administrator during the exit conference on monitored to ensure the deficient 9/29/2015. practice will not reoccur, i.e., what K 069 NFPA 101 LIFE SAFETY CODE STANDARD K 069 quality assurance program will be put SS=D into place? Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by:

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938								
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
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NAME OF F	PROVIDER OR SUPPLIER		١	S				
LIFE CARE CENTER OF MORGAN COUNTY					19 SOUTH KINGSTON STREET /ARTBURG, TN 37887			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 062	Based on observation maintain the sprint. The findings included Observation with the sprint of the following; 1. One tarnished dishwasher room. 2. One of one sprint of the sprint of	is not met as evidenced by: ation, the facility failed to kler system. de: he maintenance director on 2:00 AM and 3:00 PM, revealed sprinkler head in the (NFPA 25, 5.2.1.1.1) rinkler head in the cooler was nd foreign material. (NFPA 25, head in the shower room vas covered with foreign	K	062	The Maintenance Director or maintenance assistant will report findings of the audit to the interdisciplinary PI committee for 3 months or until 100% compliance is achieved. The Performance improvement committee includes the Executive Director, Director of Nursing, Medical Director, Consultant Pharmacist, Director of Rehabilitation Services, director of Health Information, Director of Social Services, Director of Food Services, Director of Maintenance, Staff Development Coordinator, Director of Environmental Services, and other Interdisciplinary teanf members. The PI committee will review the results of the audit. If deemed necessary by the committee, the process will be evaluated/revised and /or the audits reviewed for 3 months or until 100% compliance is achieved.			
K 069 SS=D	6. An escutcheon These findings we Supervisor and ac Administrator during/29/2015. NFPA 101 LIFE SA Cooking facilities	is missing in the freezer. re verified by the Maintenance knowledged by the ng the exit conference on AFETY CODE STANDARD are protected in accordance .2.6, NFPA 96	K	069	K 069 1. What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice? The Maintenance Director has installed a cable that will restrict		Oct. 16, 2015	
	This STANDARD	is not met as evidenced by:			movement to prevent the flexible ga line from overextending. This was completed on October 5, 2015.	as 		

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 445239 8. WING 09/28/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 419 SOUTH KINGSTON STREET LIFE CARE CENTER OF MORGAN COUNTY WARTBURG, TN 37887 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) K 069 | Continued From page 4 K 069 2. How will you identify other residents Based on observation and interview, the facility having the potential to be affected by failed to ensure commercial cooking equipment the same deficient practice? producing steam or grease-laden vapors were located under a commercial hood.(NFPA 96) The cable has been permanently place so removal cannot be The findings include: Based on observation and interview, the facility accomplished. All other equipment is failed to ensure commercial cooking equipment secured. All equipment has been complies with NFPA 54. assessed to verify that it is secured permanently in place to prevent The finding includes: movement by the maintenance director. This was completed by the The natural gas oven, double steamer and fryer maintenance director. were on casters and their movement was not restricted to prevent the flexible gas line from What measures will be put into place overextending. or what systemic changes will be This finding was verified by the Maintenance made to ensure that the deficient Supervisor and acknowledged by the practice does not recur? Administrator during the exit conference on The Maintenance Director or assistant 9/29/2015. maintenance will review monthly to K 130 NFPA 101 MISCELLANEOUS K 130 assure cable is properly placed. SS=D OTHER LSC DEFICIENCY NOT ON 2786 How will the corrective action be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place? This STANDARD is not met as evidenced by: Based on observation and staff interview, the The Maintenance Director or facility failed to maintain the fire resistance of fire maintenance assistant will report barriers and communicating openings. findings of the audit to the (NFPA 101 2000 Edition Section 8.3,5.1, interdisciplinary PI committee for 3 19.1.1.1.2, 19.1.1.4.1, 19.1.1.4.2) months or until 100% compliance is achieved. Findings include: The Performance improvement Observation and interview with the Maintenance committee includes the Executive Director, on 9/29/2015 at 10:40 AM, confirmed the kitchen's 1-hour rated ceiling was improperly

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	KS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	<u>). 0938-0391 </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION - MAIN BUILDING 01		TE SURVEY MPLETED
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NAME OF I	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	•	
LIFE CA	RE CENTER OF MOR	GAN COUNTY	Ì		SOUTH KINGSTON STREET		
				WAF	RTBURG, TN 37887		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	,	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 069	failed to ensure con producing steam of located under a confirm findings included assed on observation failed to ensure concomplies with NFP. The finding included The natural gas owwere on casters and restricted to prever overextending. This finding was vereally as a supervisor and acknowledges.	tion and interview, the facility mmercial cooking equipment of grease-laden vapors were mmercial hood.(NFPA 96) e: ion and interview, the facility mmercial cooking equipment A 54. s: en, double steamer and fryer of their movement was not at the flexible gas line from erified by the Maintenance	KO	69	Director, Director of Nursing, Medic Director, Consultant Pharmacist, Director of Rehabilitation Services, director of Health Information, Director of Social Services, Director Food Services, Director of Maintenance, Staff Development Coordinator, Director of Environmental Services, and other Interdisciplinary team members. TI PI committee will review the results of the audit. If deemed necessary the committee, the process will be evaluated/revised and /or the audit reviewed for 3 months or until 100 compliance is achieved.	of ne s by	
K 120	9/29/2015.	LANEOUC		20	К 130		
SS=D		CIENCY NOT ON 2786	K 1	Ì	What corrective action(s) will be accomplished for those residents found to have been effected by th deficient practice? The Maintenance director has	e	Nov. 2, 2015
	Based on observata facility failed to mai barriers and comm (NFPA 101 2000 Ed 19.1.1.1.2, 19.1.1.4) Findings include: Observation and in Director, on 9/29/20	s not met as evidenced by: tion and staff interview, the ntain the fire resistance of fire unicating openings. dition Section 8.3.5.1, .1, 19.1.1.4.2) terview with the Maintenance of at 10:40 AM, confirmed reated ceiling was improperly		2.	installed patch work that meets th hour rated materials on the ceiling This was completed on 10/12/201	t. 5. nts i by	

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER; COMPLETED A. BUILDING 01 - MAIN BUILDING 01 445239 B. WING 09/28/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 419 SOUTH KINGSTON STREET LIFE CARE CENTER OF MORGAN COUNTY WARTBURG, TN 37887 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) What measures will be put into place K 130 | Continued From page 5 K 130 or what systemic changes will be patched in several locations with a non-rated, made to ensure that the deficient non-listed fiberglass reinforced panel (FRP). practice does not recur? This finding was verified by the Maintenance Supervisor and acknowledged by the The Maintenance Director or Administrator during the exit conference on maintenance assistant will do a walk 9/29/2015. through assessment with the K 147 NFPA 101 LIFE SAFETY CODE STANDARD K 147 Executive Director monthly to assure SS=D our facility maintains compliance. Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1,2 How will the corrective action be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put This STANDARD is not met-as-evidenced by: into place? Based on observation and interview, the facility failed to ensure medical devices were plugged The Maintenance Director or directly into a wall receptable. maintenance assistant will report (NFPA 99, 3-3.2.1.2 (d) (2). findings of the audit to the The findings include: interdisciplinary PI committee for 3 Observation and interview with the Maintenance months or until 100% compliance is Director, on 9/29/2015 at 11:07 AM confirmed the achieved. use of a power strip in resident room 206 with one (1) power strip with a medical device plugged The Performance improvement into it. committee includes the Executive This finding was verified by the Maintenance Director, Director of Nursing, Medical Supervisor and acknowledged by the Director, Consultant Pharmacist, Administrator during the exit conference on Director of Rehabilitation Services, 9/29/2015. director of Health Information, Director of Social Services, Director of Food Services, Director of Maintenance, Staff Development Coordinator, Director of Environmental Services, and other Interdisciplinary team members. The PI committee will review the results of the audit. If deemed necessary by the committee, the process will be

DEPARTMENT OF HEALTH AND HUMAN SERVICES

evaluated/revised and /or the audits

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DAT	E SURVEY APLETED
		445239	B. WING			09/	/28/2015
	PROVIDER OR SUPPLIER RE CENTER OF MOR	GAN COUNTY	·	419	REET ADDRESS, CITY, STATE, ZIP CODE	,	2012010
////	SUMMADV STA	TEMENT OF DEFICIENCIES		WA	ARTBURG, TN 37887		·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 130	non-listed fiberglas This finding was ve Supervisor and ack	ocations with a non-rated, s reinforced panel (FRP). rified by the Maintenance	K 1	130	reviewed for 3 months or until 100% compliance is achieved.		Oct 16 2045
K 147 SS=D	NFPA 101 LIFE SA Electrical wiring and	FETY CODE STANDARD d equipment is in accordance onal Electrical Code. 9.1.2	K1	47	K 147 What corrective action(s) will be accomplished for those residents for have been effected by the deficient practice? 	ind to	Oct. 16, 2015
	Based on observation failed to ensure me directly into a wall management (NFPA 99, 3-3.2.1.2). The findings included Observation and into Director, on 9/29/20 use of a power striptone (1) power striptinto it. This finding was versupervisor and acknowledged.	e: (d) (2). e: erview with the Maintenance 115 at 11:07 AM confirmed the in resident room 206 with with a medical device plugged rified by the Maintenance			The Maintenance Director removed power strip on 9/29/15 to assure compliance. 2. How will you identify other residents having the potential to be affected became deficient practice? The Maintenance Director examined building to ensure all power strips have been removed and all medical equip has been plug into the proper wall so A letter was sent to all residents/fam to address this issue. 3. What measures will be put into place what systemic changes will be made ensure that the deficient practice do recur? The Maintenance Director or maintenassistant will do a walk through with Executive Director weekly to assure of facility maintains compliance.	the the ment ockets. tilies	

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				NO. 0938-0391				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 C (X3) E						
		445239	B. WING	09/28/2015						
	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			STREET ADDRESS, CITY, STATE, ZIP CODE 419 SOUTH KINGSTON STREET WARTBURG, TN 37887 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CONSTRUCTIVE ACTION SHOULD						
K 147	non-listed fiberglas This finding was ve Supervisor and ack Administrator durin 9/29/2015.	locations with a non-rated, s reinforced panel (FRP). rified by the Maintenance	and the state of t	130 147	4. How will the corrective action be	ctico				
SS=D	This STANDARD i Based on observa failed to ensure me directly into a wall r (NFPA 99, 3-3.2.1.2 The findings includ Observation and in Director, on 9/29/20 use of a power strip one (1) power strip into it. This finding was ve Supervisor and ack	2 (d) (2). le: lerview with the Maintenance 315 at 11:07 AM confirmed the o in resident room 206 with with a medical device plugged rified by the Maintenance			monitored to ensure the deficient practival not reoccur, i.e., what quality assurance program will be put into plate the interdisciplinary PI committee for months or until 100% compliance is achieved. The Performance improvement commincludes the Executive Director, Direct Nursing, Medical Director, Consultant Pharmacist, Director of Rehabilitation Services, director of Health Information Director of Social Services, Director of Food Services, Director of Maintenance Staff Development Coordinator, Director of Environmental Services, and other interdisciplinary team members. The committee will review the results of the audit. If deemed necessary by the committee, the process will be evaluated/revised and /or the audits reviewed for 3 months or until 100% compliance is achieved.	ance dit to 3 nittee tor of con, f cce, ctor				